MISSOURI DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
STATE SCHOOLS FOR SEVERELY HANDICAPPED
P.O. BOX 480
JEFFERSON CITY, MO 65102-0480

PHYSICAL EXAMINATION REPORT

Note to Physician: Please fill out this report fully.
This is an important record we need concerning this student's health. It is imperative to fill out each item completely.

Student's Name	Sex	Date of Birth	Age	State School Name

B/P	Pulse	Allergies: ☐ no ☐ yes If yes please list:

Seizures	Scoliosis-Degree	History of varicella ☐ no ☐ yes Date:_____

Systems Examination	**Examined**	**Not Examined**	**Comments About Findings**
General Appearance			
Nutritional Status			
Posture/Motor Behavior			
Skin			
Head			
Eyes			
Ears			
Nose			
Throat			
Mouth/Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Bones, Joints, Muscles			
Neurological			
Other:			

Medical Diagnoses: _____
_____

Please note any health problem, chronic health condition or disability that may affect behavior or health at school: _____
_____
_____

Medication (Required At School): ☐ **No** ☐ **Yes** **If yes a medication order form must be completed before medication will be administered at school.**

IMPORTANT: In my opinion this student's physical condition **will** allow him/her to participate in the following **adaptive P.E.** activities, which will include direct supervision. For individuals with Down syndrome, this opinion is offered in consideration of the implications of atlantoaxial instability.
Please place a checkmark to indicate which activities are appropriate for this student's physical condition.

	Mild	Moderate	Strenuous	Not applicable		Mild	Moderate	Strenuous	Not applicable
Bowling	☐	☐	☐	☐	Jumping	☐	☐	☐	☐
Rhythmic Activities	☐	☐	☐	☐	Weight Lifting	☐	☐	☐	☐
Trampoline	☐	☐	☐	☐	Climbing	☐	☐	☐	☐
Roller Skating	☐	☐	☐	☐	Bicycling	☐	☐	☐	☐
Running	☐	☐	☐	☐	Tumbling	☐	☐	☐	☐
Swimming	☐	☐	☐	☐	Wrestling	☐	☐	☐	☐
Treadmill	☐	☐	☐	☐	Physical Fitness Program (i.e. walking, exercise, etc.)	☐	☐	☐	☐

Healthcare Provider's Full Name (Print) (M.D., D.O. or Nurse Practitioner)	Healthcare Provider's Signature	Telephone Number	Date